Vital Sleep Care

NEW ADULT PATIENT FORM

Please complete this form entirely.
You will also need to bring your photo ID, insurance card and method of payment with you to your appointment.

Patient Registration & Demographic Form

PATIENT INFORMATION

Patient's Name: (Last) _____ (First)_____(M)_____

Sex: _____ Age: _____ Date of Birth: _____/_____/_____

Social Security #: _____-_____-_____

Address: _____

City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Contact Preference _____

Race: _____ ___Ethnicity: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Primary Care Doctor: _____

Referring Doctor: _____

How did you hear about us? _____

Emergency Contact Name: _____ Relation: _____

Phone #: _____

Employer Name: _____

Phone # _____

Pharmacy Name/Address/Phone:

_____

GUARANTOR OF ACCOUNT INFORMATION (IF OTHER THAN PATIENT)

Name: _____ Relationship: _____ DOB _____

Address_____

Home Phone: _____Cell Phone: _____ Work Phone: _____

INUSRANCE CARD & PHOTO ID MUST BE PROVIDED AT THE TIME OF THE APPOINTMENT

I acknowledge the information I provided above is true and correct.

X _____ Date: _____/_____/_____

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Statement of Consents

Provide Treatment: I authorize Vital Sleep Care to provide me treatment as necessary, and such treatment will be mutually agreed upon. I authorize my insurance benefits to be paid directly to Vital Sleep Care. I acknowledge my financial responsibility for payment of services to me including any non-covered or denied services by my insurance.

Release of Information: I have reviewed Vital Sleep Care's Notice of Privacy Policies which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document. I authorize the release of information to my insurance concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and / or primary care physician. This information will include diagnosis, treatment plans and services provided. I authorize the release of information to the following individuals until revoked by me in writing:

_____/ _____/ _____

Name / Relationship / Phone

_____/ _____/ _____

Name / Relationship / Phone

Photo: During registration I may have a photo taken and attached to my chart as a means of greater identification. I understand if I have my photo taken it will be used solely for that purpose and no other.

Communication: I understand the need for Vital Sleep Care to contact me regarding multiple reasons including appointments, treatment, follow-up and billing issues. I wish not to restrict Vital Sleep Care or those operating on behalf of Vital Sleep Care from contacting me in all usual and customary manners. I have provided all acceptable modes of communication and contact information during registration. I will keep Vital Sleep Care updated should any of this information change.

Reviews & Testimonials: I understand that the reviews and testimonials provided by me to Vital Sleep Care or its providers will be posted on company website and/or any social website of practice's choice. I understand that my name may be displayed with the review and/or testimonial depending on the social website policy.

I acknowledge Vital Sleep Care has requested, I register with Patient Portal as a means of greater access and efficient communication. I understand this is a secure means of electronic communication that requires a password and email address to facilitate an exchange of information. I understand that any electronic communication may contain personal information relating to my medical care. It is my responsibility to safeguard my password to Patient Portal.

I acknowledge having read Statement of Consents and understand its meaning and purpose.

X _____ Date: _____/_____/_____

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Authorization for Disclosure of Protected Health Information (PHI)

Patient Name: _____ Patient DOB: _____

Address: _____ City: _____

State: _____ Zip: _____

SSN: _____ Telephone: _____

Information Requested From
Name of Person/Company: _____

Phone Number: _____ Fax Number: _____

Address: _____ City: _____

State: _____ Zip: _____

Send Information To
Name of Person/Company: _____

Phone Number: _____ Fax Number: _____

Address: _____ City: _____

State: _____ Zip: _____

Please Select Information to be Disclosed:

☐ Sleep Study Reports ☐ Progress Notes ☐ Lab reports ☐ Medication List

☐ Billing/ Financial Information ☐ History and Physical

☐ Other: _____

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before they receive my written notice of revocation.

By signing this form, I authorize the entities listed above to disclose my confidential health information by releasing a copy of the requested medical records.

Signature: _____ Date: _____/_____/_____

Legal Representative: _____

Relationship to Patient: _____

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General Practice Policies

The information provided in this document explains what you can expect as a patient of Vital Sleep Care and outlines your responsibilities. Please familiarize yourself with the entire document. A copy will be provided to you. A member of our staff is available to answer your questions. Thank you for placing your trust and confidence with Vital Sleep Care.

Appointments: Please arrive prior to your appointment time. Patients arriving 15 min late may be asked to reschedule. An appointment reminder will be communicated with you 4 days and a day prior to your appointment by text message and / or phone call. Confirming your appointment is required.

Appointment Cancellations / No Shows: **Appointment Cancellations / No Shows:** We understand unexpected things happen. Please be courteous and contact the office 24 hours in advance should you be unable to keep your scheduled appointment. In addition to appointments no shows, appointments not cancelled or rescheduled 24 hours prior to the appointment time are also considered as no show. You will be charged a **$35 fee** for a no show follow up office visits. These charges will not be covered by insurance. A pattern of multiple missed appointments is considered being noncompliant with your healthcare and may cause dismissal from the practice.

You will be asked to confirm your demographic and insurance information each time you visit.

Financial Responsibility: All applicable fees, deductibles, co-insurance, and copays are collected at the time of service. Balances billed to the patient are due within 30 days of the statement date. Past due balances are subject to collection activity and associated fees. A **$50 service fee** will be charged to your account for checks returned by your bank. You, or your guarantor, are financially responsible for all charges relating to healthcare services received. Please contact our insurance coordinator in advance with any questions regarding insurance and billing at (256) 464-2920. Self-pay patients are due payment at the time of service.

If your account is placed in collections status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collection agency fees, court costs, interest, and fines. These payments in full are patient's responsibility, insurance will not cover these charges.

Insurance Referrals: Most HMO's and some insurance plans require the patient to obtain a referral from their primary care physician to be treated by a specialist. In this instance, Vital Sleep Care must receive the referral prior to scheduling an appointment.

Initial: _____ **Date:** _____

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Medical Staff: The care you receive will always remain under the direct supervision of Leelasri Vanguru, MD, Fellowship Trained and Board Certified in Sleep Medicine. Participating in the care of every patient are advanced practice providers who have completed advanced graduate level education and training. They work in collaboration with Dr. Vanguru to diagnose and treat conditions pertaining to sleep medicine.

Communications: Our staff work closely with the providers managing your care and play an integral role in daily communication with patients. Many questions or concerns can be addressed by communicating directly with them. As an efficient means of communication with the office you will be invited via email to register with the Patient Portal. The portal is a secure way to send and receive messages.

Prescription Refills: Controlled substance refills need office appointment, and it is patient's responsibility to keep their appointments as scheduled before they run out of the medication. For other medication refills, contact your pharmacy/physician at least 7 days in advance. Your pharmacy will communicate with our office for all required information. Please be aware no refill requests will be completed after hours or over weekends. Please allow two business days to process a request and five business days if your insurance requires a prior authorization. **You will be charged $35 for staff obtaining a prior authorization.**

Medical Records: You may, in writing, request a copy of your medical records for personal use, attorneys, insurance purposes, disability determination and various other reasons. Copies may be provided as a paper copy or electronically within 15 days of receiving your request. You may be charged for this at one dollar ($1.00) per page for the first twenty-five (25) pages, fifty cents ($.50) per page for each page in excess of twenty-five (25) pages, plus the actual cost of mailing the record.

Additional Services: Occasionally some administrative fees will occur that are not covered by insurance. These services include but are not limited to medical record release fees, depositions, completing forms, no show fees, returned check fees and medication prior authorization. You will be charged for these services should they be necessary.

Medical Compliance: A relationship of mutual respect is the basis for a proper plan of care. Patients who become noncompliant with their prescribed treatment plan may be subject to dismissal from Vital Sleep Care.

I acknowledge having read General Practice Polices and understand its meaning and purpose.

X _____ Date: _____/_____/_____

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Medical History Questionnaire

Reason for today's visit: _____

How long have you had this problem? _____

Weight gain or loss over the last 5 years? _____

How much? _____

Sleep schedule history:

On average, how many hours do you sleep at night? :

What is your usual bedtime?:

How long does it take usually to fall asleep?:

When do you wake up in the morning usually?:

How many times do you usually wake up during the night?:

How soon can you usually fall back to sleep?:

What are the reasons for you to wake up during the night?

_____

Any naps during daytime? Planned or Unplanned

How often do you usually nap? _____

How long are these naps usually? _____

Usual sleep schedule on weekends: _____

Sleep apnea symptoms (Check the ones that are positive for you):

- □ Snoring
- □ Gagging or gasping or choking or snorting
- □ Witnessed apneas
- □ Feel excessively sleepy during daytime
- □ Feel tired during daytime
- □ Morning headaches
- □ Waking up to urinate multiple times in the middle of the sleep
- □ Waking up feeling unrested
- □ Drooling
- □ Dry mouth

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Other sleep symptoms (Check the ones that are positive for you):

- □ Fall asleep suddenly at inappropriate situations
- □ Weakness in any part of body when excited or laughter
- □ Hallucinations when falling to sleep or waking up from sleep
- □ Sleep paralysis- Feeling unable to move or talk when waking up
- □ Leg discomfort at night that makes you want to move them or stretch
- □ Unknowingly kicking legs in bed
- □ Sleep walking or talking or eating
- □ Enacting dreams
- □ Bad dreams or nightmares
- □ Teeth grinding

- Caffeinated beverages: How many per day? _____
- Drowsy driving: □ Yes □ No
- Accidents due to sleep problems: □ Yes □ No
- In bed, □ Reading □ Eating □ Watching or playing with electronics

Epsworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale to choose the most appropriate number for each situation:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing (0-3)
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theatre or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____
Total	_____

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Review of systems: Do you have these? Circle that are positive.

Constitutional: Fever, Chills, Night Sweats

Eyes: Dry eyes, Glaucoma, vision change

ENT/Mouth: Nasal Congestion or discharge, Sinus Pain, Hoarseness, Sore throat, Swallowing di fficulty

Endocrine: Abnormally increased quantities of urine, Abnormally excessive thirst

Respiratory: Cough, Shortness of breath, Sputum production, Wheezing

Cardiovascular: Chest Pain, Swelling of extremities, Palpitations, Murmur

Gastrointestinal: Heart burn, Abdominal pain, Loss or increased appetite, Nausea

Heme/Lymph: Bruising, Anemia, Elevated hemoglobin/RBCs

Genitourinary: Urinary urgency, Increased urinary frequency

Musculoskeletal: Joint pain, muscle pain, back pain, neck pain

Skin: Skin Lesions, Skin itching

Neuro: Extremity weakness, Abnormal sensation, Dizziness, Headache, Coordination changes

Psych: Insomnia, Panic attacks, Personality Changes, Hallucinations, Memory Changes, Violence/Abuse Hx.

Past and current medical/psychiatric problems:

□ High blood pressure	□ High Cholesterol	□ Heart attack	□ Arrhythmias
□ Heart failure	□ Headaches	□ Stroke	□ COPD
□ Asthma	□ Seasonal allergies	□ Diabetes	□ Heartburn
□ Depression	□ Anxiety	□ PTSD	□ Glaucoma
□ Hypothyroidism	□ ADD	□ Vitamin D deficiency	
□ Chronic pain	□ Hearing loss	□ Seizure disorder	□ Any others:

_____

_____

_____

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Surgeries: List all surgeries you underwent

☐ Tonsillectomy ☐ Adenoidectomy

_____

_____

_____

Family history:

Any family members had or has sleep apnea? _____

Any family members had or has insomnia? _____

Any family members had or has narcolepsy? _____

Any family members had or has restless legs? _____

Any family members had or has any other sleep problems? _____

Social history:

- Smoking: □ Never □ Former – Quit date:
  □ Current How many per day? _____
  For how many years? _____
- Alcohol: □ Never □ Former – Quit date:
  □ Current How often? _____ How many at a time? _____
- Recreational drugs: □ Never □ Former – Quit date:
  □ Current What? _____
- □ Living with family/friends □ Living alone
- Occupation: _____ Shift: _____

Medications: List all your current medications – prescribed and over the counter

_____

_____

_____

_____

Allergies with reaction:

Any medication allergies: _____

Any food allergies: _____